



World Federation of Vascular Societies: Presidential Address

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Abstract The presidential address describes briefly the history of the World Federation for Vascular Societies (WFVS) and its objectives. Vascular Surgery today includes interventional procedures (open surgical and endovascular) in addition to risk factor reduction and medical treatment. It is equally important to train in clinical investigative methods, non-surgical treatment, decision making as is training in technical aspects of interventions. Similarly, it is vital, that the vascular specialist always recommends the treatment which is best to the individual patient, not only what he can do or what is best for other reasons, i.e. financial.

Due to the increasing complex procedures - endovascular evolution and what is then "left" for open surgery - specialisation into "mainly open vascular surgeon" and "mainly endovascular surgeon" preceded by a common basic training into both, seems unavoidable. Similar, in order to be able to train with relevant case mix and numbers, and in order always to have both complex open and endovascular skills on call 24 hours per day, 365 days a year, centralisation into larger units is necessary.

The WFVS is important simply looking at the huge demographic differences throughout the world. In addition, for introduction of new treatments, training issues and dissemination of science a global organisation like the WFVS is needed.

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History and Objectives

The World Federation for Vascular Societies (WFVS) is now 2 years past inauguration; today the European Society for Vascular Surgery (ESVS) is hosting the third annual meeting. The inaugural meeting was held in Madrid during the ESVS

meeting in September 2007, the second meeting in San Diego during the annual meeting of the Society for Vascular Surgery (SVS) in June 2008 and this year we are meeting here in Oslo.

From the beginning, the WFVS had representation from six regions: Australia–New Zealand (Australia New Zealand Society for Vascular Surgery (ANZSVS)), Japan (Japanese Society for Vascular Surgery (JSVS)), India (Vascular Society of India (VSI)), South Africa (Vascular Surgical Society of South Africa (VASSA)), North America (Society European Society for

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Figure 1 President for WFVS Henrik Sillesen at the annual meeting in Oslo.

Vascular Surgery (SVS)) and Europe (European Society for Vascular Surgery (ESVS)). Later, Asia was represented by the Asian Society for Vascular Surgery (ASVS). Last year South America was represented by the Brazilian Society for Angiology and Vascular Surgery (SBACV), and this year, the Middle East has joined the World Federation. I am happy to announce the membership of the Orient Society for Vascular Surgery (OSVS). Each of these regional societies has a council member. The presidency rotates every year and represents the regional society hosting the forthcoming annual meeting. I am proud to have served as the WFVS president 2008–2009 with the annual meeting being held here in Oslo during the annual ESVS meeting Fig. 1.

The main objectives of the WFVS are to have a platform for exchange of scientific, educational and political matters related to management of vascular diseases. Having grown out of vascular surgical societies, I think most of us, if not all, realise that vascular surgical procedures are only a part of treatment of vascular disease. In addition, vascular surgery and patients suffering from vascular disease do better when accompanied by good medical treatment. It is interesting to look back at the past 10–15 years prior to which medical treatment for vascular disease was recognised mainly as aspirin and anti-coagulation therapy for some.

What is Vascular Surgery Today?

Invasive interventional procedures, open surgical and increasingly endovascular alternatives, remain the backbone of what we do and train for. However, patient evaluation and selection of the right treatment for the individual patient are increasingly being recognised as vital for the chance of successful outcome of a procedure. So not only should we worry about how to train young surgeons

technically, equally important is training in the decision processes that precedes surgical planning. That we focus our training towards the more advanced stages of vascular disease (e.g., large aneurysms, symptomatic occlusive atherosclerotic disease and symptomatic venous disease) is only natural since the earlier stages of vascular diseases in most cases are easy to treat and can be dealt with in primary care. More advanced stages need evaluation by someone who can offer surgical treatment (open as well as endovascular) when indicated and optimal medical treatment for all – the vascular specialist.

Therefore, training to become a good vascular surgeon includes training to become a good doctor. Treating vascular patients includes not only the technical aspects of the procedure, being it endovascular or open, but it is equally important to ensure that the treatment offered is the best for the individual patient, not just what the attending physician himself is able to perform or what is most attractive with respect to income. Aggressive medical therapy has been shown to be very beneficial for our patients.^{1–4} Recently, preoperative risk factor reduction (smoking cessation especially) as well as preoperative medical treatment has been shown to reduce surgical morbidity and mortality.^{5–7} Thus, the issue of vascular surgeons needing to become vascular specialists is truly based on evidence showing a benefit to our patients. Rather than surgeons being someone waiting for other doctors to refer patients for surgery, we wish to be the experts that patients are referred to for evaluation of total treatment needed. I am sure that only few vascular surgeons wish to end in a situation as cardiac surgeons where cardiologists decide which patients the cardiac surgeons may operate.

Along the same lines, the ability of the vascular surgeon (specialist) to perform/evaluate simple and advanced vascular testing is extremely valuable. This means that we, during one consultation (i.e., the first), in many cases may evaluate and investigate the patient and suggest a treatment plan for the patient. Not many specialties are able to do that. Not only is this nice for the patient, but most certainly it also results in better quality of treatment. Having the same person evaluating and performing the ultrasound scan (or someone else working in the vascular laboratory) will ensure that the findings of the scan will be interpreted rightly according to the patient symptoms and objective findings.

Endovascular treatment

Endovascular treatment has many advantages over open surgery, provided that outcomes are comparable – and in many clinical situations, this is the case or almost the case. For instance, nobody is anymore in doubt that local occlusive disease in the common iliac arteries, in the vast majority of cases, are best treated with endovascular techniques. With the increasing use of endovascular techniques, it is only natural that we as vascular surgeons have had a wish to perform them ourselves. Given that we are those who evaluate, investigate, make indications, perform open surgery and perform follow-up in vascular patients, we also want to be able to do the less invasive interventions. Many vascular surgeons have trained in and now perform endovascular interventions in addition to open

surgery. In fact, among vascular surgeons, we now have many endovascular experts. However, in many countries, vascular surgeons have only just begun or are still waiting to begin. In my own country, Denmark, we have had a long-standing good relationship with interventional radiologists, who have served us, and our patients, very well. The backside of this long-standing and good relationship is that it makes it much more difficult to get into the 'angio-room' for us surgeons now. Interventional radiologists do not see the same need for us to train in endovascular techniques as we do ourselves (maybe not surprising after all). In a country where health care and doctors specialisation is much regulated, we are facing a long process before we will be able to do endovascular interventions on our own. The best solution would certainly be a merger with those among interventional radiology who wish to work with vascular patients! In this manner, all doctors treating vascular patients could take part in patient evaluation, decision making on indications, follow-up, etc.

Specialisation within vascular treatment (surgery)

With the development of endovascular procedures now being able to replace open surgical techniques in many cases, the need for adjusted training has emerged. Where vascular surgeons have wished to perform these treatments, they have had to learn doing them and many countries training programmes for vascular fellows have changed accordingly. Being able to treat more and more conditions with endovascular techniques the number of open surgical procedures to train new vascular surgeons are becoming less. At the same time, since those procedures that work best with endovascular management most often are the least complex, those left for open surgical repair are the most complex and those that require highest level are open surgical skills.

In fact, we are facing the dilemma that because endovascular techniques successfully are replacing some, but not nearly all open surgical procedures, we will need to be good at both, thus new vascular surgeons will need to train both. At the same time, the number of cases available to train has to be divided between the two techniques. Further challenging, as mentioned, those left for open surgery are the more complex cases and with least volume, how do we ensure that we will have good surgeons for those cases in the future? Sub-specialisation within our specialty seems the only solution. It is tempting to consider a uniform basic training in both techniques and later sub-specialisation into either. In this way, the vascular physician specialised in open surgery could still perform some endovascular procedures, that is, inflow before a fem-distal bypass and the endovascular specialist could perform a complex stent-graft procedure with over-stenting a major vessel, followed by open surgical revascularisation.

Consequently, when numbers to train need to increase owing to more treatment alternatives (open and endovascular) larger patient volumes are required. In addition to the training issues mentioned above, keeping two groups of specialists with a basic annual volume to retain skills further adds to the need for centralisation. To have experts in both open and endovascular techniques available to treat patients 24 h a day, 365 days a year, we will need to

centralise treatment into larger units. The evolution of gathering vascular procedures into larger centres is already happening in many countries not least in Scandinavia (i.e., Helsinki, Stockholm and Copenhagen).

What is the Role of the WFVS?

I have already mentioned the main objectives where we can learn from each others challenges and success. Simply looking at the differences in the presence of vascular surgeons in different regions reveals enormous differences: in Scandinavia, there is one vascular surgeon for every 100 000 inhabitants, in South Africa one per million and in India one per 3 million. Looking at the scientific aspect, we need to ensure that new knowledge (evidence of treatment) is disseminated throughout the world. Even in smaller parts of the world, we know that evidence may have been provided for certain treatments years before, yet we fail to implement them. The impact of worldwide organisations such as the WFVS might have an additional impact on local/regional recommendations. Similarly, with development of new techniques and treatment, we continue to experience products being marketed without evidence for its value. This is, of course, only natural when a product is new; however, widespread use by everybody is not warranted. In the vascular world, we have experienced several cases where uncontrolled introduction of new technologies or devices in retrospect were clearly inappropriate (lasers introduced in the 1990s, early stent grafts in the same period, etc.). Controlled introduction with inclusion into trials or registries should be mandatory in such cases and international societies may play a major role in reminding us all of that, disseminating data/results, co-ordinating efforts, etc.

Clearly, we cannot bring the annual WFVS meeting to all regional societies as often as we would like. With already eight member-societies, a rotation among all implies how seldom the WFVS can be present in each region. However, it is possible to bring the WFVS to local arrangements within the member-societies. For instance, this year the first WFVS symposium was held in Hyderabad, India, during the annual meeting of the Indian Vascular Society (IVS) in November 2009.

Conclusion

The WFVS is beginning its third year of existence. It has grown continuously since inauguration and now covers most regions in the world. The attendance to our meetings is increasing rapidly and, in Oslo, we filled the main auditorium. In October 2009, we have the first WFVS symposium at a regional meeting in India. The WFVS is increasingly becoming recognised and recently the WFVS was invited by the World Health Organization (WHO) to represent vascular surgery at the Global Forum for Trauma Care. I would like to end by thanking you all for letting me serve as president the past year and I wish the WFVS a great future.

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